ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS

MEDICAL MALPRACTICE RECOMMENDATIONS

November 6, 1987

SUMMARY OF RECOMMENDATIONS

1. The Task Force recommends adoption of the Prompt Resolution of Meritorious Medical Negligence Claims Plan which includes the following provisions:

   (a) Claims against physicians and denials of such claims must be preceded by reasonable investigation and accompanied by an expert's written opinion;

   (b) Incentives should be provided for claimants and health care providers to submit claims to a binding arbitration proceeding to determine the amounts of economic damages, non-economic benefits not to exceed $250,000 and reasonable attorneys' fees.

   (c) If the defendant refuses to submit the claim to arbitration, the plaintiff should retain all existing rights to a jury trial.

   (d) If the plaintiff refuses to submit a claim to arbitration, plaintiff's non-economic damages at trial should be limited to $350,000.

2. The Task Force recommends adoption of legislation allowing physicians and hospitals to participate in a no-fault plan limited to birth-related neurological injuries.

3. The Task Force recommends that the Legislature not adopt a plan that would eliminate recovery for all non-economic damages and the right to jury trial while requiring the claimant to prove fault.

4. The Task Force recommends rejection of a plan that would limit recovery of non-economic damages to $100,000 in all tort cases, including claims for medical negligence, in an attempt to solve Florida's medical malpractice problems.

5. The Task Force recommends substantially strengthened regulation of health care providers by the state of Florida. This more robust professional regulation must include not only a commitment by the Legislature to provide more resources, but also an improved administrative structure that will enable the state agency to pursue vigorously its obligation to discipline physicians whose incompetence results in medical malpractice.

6. The Task Force recommends that a separate division, to be known as the Division of Medical Quality, be created within the Department of Professional Regulation to discipline and license health care providers. This division should be funded, entirely or in part, by increases in professional licensing fees for health care providers.

7. The Task Force recommends that legislation be enacted that requires the state health care regulatory division to assume greater responsibility for medical professional discipline and quality assurance at the local level. The division should establish local quality assurance boards to identify health care provider competency and disciplinary problems at their source and to coordinate with peer review and quality assurance programs conducted by local medical societies and hospitals.

8. The Task Force recommends adoption of the Premium Impact Equity Plan. This plan provides for equity payments for those physicians who can demonstrate affirmatively that high medical malpractice premiums are creating genuine financial difficulties. The plan would be financed solely by a small tax on all medical malpractice insurance premiums.

9. The Task Force recommends rejection of any risk class compression plan requiring a state operated (or other mandatory) insurance pool.

10. The Task Force recommends rejection of any proposal which uses existing tax revenues or any other general revenues to subsidize high medical malpractice insurance premiums.

ACKNOWLEDGMENTS

These Medical Malpractice Recommendations of the Academic Task Force for Review of the Insurance and Tort Systems reflect an understanding of Florida's legal, medical and insurance systems which was gleaned from information and opinions provided by a diverse group of individuals and organizations interested in Florida's medical malpractice problems and from the efforts of the Task Force's research staff. The members of the Academic Task Force wish to express their appreciation to those organizations and individuals.

Executive Director Carl S. Hawkins, Guy Anderson Professor of Law at the J. Reuben Clark Law School of Brigham Young University, and Associate Director Donald G. Gifford, Professor of Law at the University of Florida, directed the Task Force's research and investigation into Florida's medical malpractice system and the preparation of this package of recommendations. The other members of the research team responsible for the preparation of these recommendations include Dr. David J. Nye, Associate Professor of Finance and Insurance, University of Florida; Joseph W. Little, Professor of Law, University of Florida; Dr. Roger D. Blair, Professor of Economics, University of Florida; Mr. Bernard L. Webb, Professor of Actuarial Science, Risk Management and Insurance, Georgia State University; and Dr. Marvin Dewar, M.D. The Academic Task Force also expresses its appreciation to computer programmer Michael Kelly and to research

assistants Peggy Lyon and John Davis. Finally, administrative secretary Noreen Fenner deserves special mention, not only for manuscript preparation, but for administrative responsibilities too numerous to mention.

The University of Florida, and its College of Law, donated the physical facilities used by the Academic Task Force staff and considerable administrative assistance. The Task Force appreciates the cooperation of Dean Frank T. Read and Associate Dean Jeffrey Lewis in making available office space, computer terminals and supplemental secretarial help. Florida State University and the University of Miami also have provided support for this project in a number of ways.

The Academic Task Force received the cooperation of a wide variety of governmental agencies, organizations, corporations and individuals in its research and fact-finding efforts. Many of these organizations and individuals were acknowledged in the Preliminary Fact-Finding Report on Medical Malpractice.

The Task Force would like to recognize the contributions of a group of trial lawyers and physicians whose work is the genesis for portions of the Prompt Resolution of Medical Negligence Claims Plan. This "Palm Beach Group," chaired by Ms. Barbara Pariente, proved that Florida doctors and lawyers could address difficult and contentious issues in a problem-solving mode and advance the public welfare in doing so. The Palm Beach Group's proposals do not include the conditional limit on non-economic damages described in these recommendations, and Ms. Pariente specifically requested that her group be disassociated from any limit on non-economic damages. The Task Force's gratitude for

the valuable contributions made by the Palm Beach Group, however, remains undiminished.

Despite the assistance of these many groups and individuals, these recommendations remain solely the responsibility of the Task Force and its research staff.

INTRODUCTION

Florida's Academic Task Force for Review of the Insurance and Tort Systems was established by the Tort and Insurance Reform Act of 1986.[1] It directed the Task Force to study problems involving affordability and availability of liability insurance, to review the impact of newly enacted reforms contained in the 1986 legislation and to report its findings and recommendations by March 1, 1988.

The Academic Task Force for Review of the Insurance and Tort Systems differs from commissions and advisory committees that have investigated the tort and insurance systems in other jurisdictions. The majority of these other special commissions have consisted of various combinations of representatives of those interest groups most directly affected by the tort and insurance systems---trial lawyers, doctors, insurance industry spokespersons and business representatives. Most often, these commissions operated within unrealistically short time frames and without necessary professional assistance.

Unlike these other efforts, the Academic Task Force does not consist of representatives of the various affected parties. Instead, its members are the presidents of three major Florida universities and two businessmen with distinguished public service backgrounds selected by the three university presidents: Chairman Marshall Criser (President, University of Florida); Edward T. Foote, II (President, University of Miami); Preston Haskell (President, the Haskell Company, Architects/Engineers/

Contractors); P. Scott Linder (Chairman of Linder Industrial Machinery Company); and Bernard F. Sliger (President, Florida State University). The Florida task force also differs from other groups because it has a sufficient budget to hire a professional staff with expertise in insurance and finance, actuarial science, law, economics and medicine.

As the Task Force and its research staff began their investigation, medical malpractice emerged as the most visible and probably the most serious area of concern within the tort and insurance systems. On July 2, 1987 Governor Martinez met with Marshall Criser, Chairman of the Task Force, and with several representatives of the Task Force's research staff. At the request of Governor Martinez, the Task Force expedited completion of its research efforts relating to Florida's medical malpractice problems.

On August 14, 1987 the Academic Task Force released its Preliminary Fact-Finding Report on Medical Malpractice. This report, based upon research conducted by the Task Force professional staff, analyzed the extent of the problems in the state of Florida regarding the affordability and availability of medical malpractice insurance. It also diagnosed the underlying causes of these problems. The research effort supporting the Task Force findings is believed to be the most comprehensive effort to determine the causes of malpractice problems conducted anywhere in the United States.

On September 8, 1987 Governor Martinez again contacted Chairman Criser and requested that the Academic Task Force prepare recommendations for addressing Florida's medical

malpractice problems by November 1, 1987. This report, Medical Malpractice Recommendations, is a response to the requests from the Governor and from others who have urged the Academic Task Force to provide recommendations at an earlier time than the March 1, 1988 deadline originally set by the Legislature.

These Medical Malpractice Recommendations are based upon the Task Force findings contained in the Preliminary Fact-Finding Report on Medical Malpractice and are tailored specifically to address the underlying causes of Florida's medical malpractice problems. The Task Force has not tried to formulate a plan with an objective of achieving political consensus. Rather the goal has been to address malpractice problems from the perspective of what measures can satisfy the basic premises of the tort and insurance systems as applied in the medical malpractice field.

The plan outlined here includes civil justice reforms, strengthened regulation of the medical profession and a proposal to provide immediate relief for physicians who experience genuine financial difficulty as a result of high premiums. Too often in the debate about medical malpractice, solutions addressing one aspect of the problem are seen as mutually exclusive of reforms in other areas. The Task Force believes that reforms of the civil justice system, of the medical regulatory system, and of the insurance system complement each other. All are necessary to address the complex problems with multiple causes analyzed in the Preliminary Fact-Finding Report on Medical Malpractice.

Some of these recommendations are entirely new proposals; others combine aspects of various prior proposals in innovative ways. The Task Force and its research staff evaluated the advisability of all reform proposals of which they were aware.[2] Except for those proposals specifically discussed in these Medical Malpractice Recommendations, the Task Force does not endorse any of the other options which it considered.

Because these recommendations are based upon the findings of the Preliminary Fact-Finding Report on Medical Malpractice, some of the more important conclusions from that report should be emphasized. The Task Force found that medical malpractice insurance premiums increased dramatically during the past eight years, with the largest share of this increase coming during the past two years.[3] Increased medical malpractice insurance premiums have resulted in increased health care costs, and for some physicians malpractice premiums may be so costly as to make liability insurance "functionally unavailable."[4] Further, the Task Force concluded that liability insurance affordability problems in the medical malpractice area are substantially more serious than in most other areas of liability insurance.[5]

The Task Force stated in its Preliminary Fact-Finding Report on Insurance and Tort Systems that the primary cause of increased malpractice premiums has been the substantial increase in loss payments to claimants and not excessive insurance company profits nor the insurance industry underwriting cycle.[6] Further, the Task Force found that the dramatic increase in the size or amounts of paid claims was the major cause of the increase in total claims payments; the frequency of claims against physicians

increased only slightly.[7] In particular, the size and increasing frequency of the very large claims were found to be a problem.[8] Finally, attorneys' fees and other litigations costs were found to represent approximately 40 percent of the total costs of insurance companies, while claimants received 43.1 percent of the insurers' total incurred costs.[9] During the past eleven years, the average cost of defending a malpractice claim had increased at an annual compound rate of seventeen percent.

The first recommendation of the Task Force, implementation of the Prompt Resolution of Meritorious Medical Negligence Claims, is designed to stabilize and reduce medical liability premiums through a fair and carefully balanced combination of civil justice reforms specifically addressed to the Task Force findings. The plan imposes verifiable requirements that reasonable investigation precede both malpractice claims and defenses in order to eliminate frivolous claims and defenses. It includes substantial incentives for both parties to investigate their cases early and to submit them to binding arbitration, thus reducing attorneys' fees, litigation costs and delay. It includes a conditional limitation on non-economic damages, but only in those cases in which the defendant concedes its willingness to pay full economic losses, limited non-economic damages and reasonable attorneys' fees. In addition to the substantial cost savings that likely will result from reduced litigation expenses and the reduction in frivolous claims and defenses, the proposal provides limits on the non-economic damage

components of large awards that otherwise often are difficult to estimate.

In those cases in which either party elects its right to jury trial, the Task Force suggests development of more specific jury instructions on the issue of the amount of non-economic damages. The Task Force and its research team intend to address this issue more fully in its March 1988 Final Report to the Legislature, and any action on this recommendation should wait until that Final Report. The Task Force mentions this recommendation here, however, to stress its importance as a complementary method to amerliorate the problems caused by large verdicts.

In its Preliminary Fact-Finding Report on Medical Malpractice, the Task Force noted that the impact of medical malpractice problems varied considerably among medical specialties.[10] Obstetricians, in particular, have faced especially high malpractice premiums, the highest percentage increases in rates during recent years, and one of the highest risks of having claims filed against them.[11] The research staff expressly recognized that a generation ago abnormal births were regarded as an inherent risk of childbirth, but that now birth injuries increasingly result in claims against obstetricians.[12] These factors, the Task Force believes, warrant distinctive treatment of birth related neurological injuries, and therefore the Task Force recommends adoption of a no-fault plan for compensation of birth related neurological injuries.

These recommendations also recognize that it is possible to reduce the cost of medical malpractice insurance by reducing injuries caused by medical negligence in the first place.

Obviously, a reduction in the occurrence of medical injuries is the most desirable manner in which to reduce the costs of the medical malpractice systems. In its Preliminary Fact-Finding Report on Medical Malpractice, the Task Force found that nearly one half the amount of paid claims during the period 1975 through 1986 was accounted for by physicians with two or more paid claims.[13] Further, the report concluded that the Department of Professional Regulation disciplines a small percentage of physicians with multiple paid claims. The Task Force cited data from the existing state agency which showed that from 1982 through June 1987, 135 physicians were disciplined for malpractice, negligence or incompetence.[14] This figure compares with 2,696 physicians with paid claims and 366 physicians with two or more paid claims.

These recommendations include a comprehensive reform package designed to strengthen professional regulation of the medical profession in the state of Florida. The plan recommends that a separate division, to be known as the Division of Medical Quality, be created within the Department of Professional Regulation and be responsible for the licensing and discipline of health care providers. This division should assume comprehensive responsibility for medical professional discipline and quality assurance. Most existing quality assurance programs are conducted at the hospital or other local level.

As mentioned previously, the impact of high medical malpractice premiums varies greatly depending on a physician's medical specialty and the area of the state in which he or she

practices. For some, particularly younger practitioners or those practicing in less affluent areas, malpractice premiums may be unaffordable. For this reason, the Task Force recommends adoption of the Premium Impact Equity Plan. This plan would provide benefits to physicians who affirmatively demonstrate that high medical malpractice premiums are causing genuine financial difficulties. It does so without impairing the continuation of medical liability coverage through the existing system of physicians' trust funds, physician owned companies and commercial carriers.

The Task Force believes that these recommendations constitute a carefully balanced set of proposals, the content of which has been determined by the results of its extensive research efforts. The Task Force recommends that the Florida Legislature adopt these proposals.

I. CIVIL JUSTICE SYSTEM REFORMS

The Task Force recommends that the Legislature adopt two proposals for reform of the civil justice system:

(1) The Prompt Resolution of Meritorious Claims Proposal; and

(2) An optional no-fault compensation system limited to catastrophic birth-related neurological injuries.

Further, the Task Force suggests that the development of more specific jury instructions to give juries guidance in awarding non-economic damages is desirable, but defers any formal recommendation on this issue until its March 1988 Final Report. Finally, the Task Force also recommends against adoption of two other proposals for reform of the civil justice system that have been offered as potential solutions to Florida's medical malpractice problems.

A. Prompt Resolution of Meritorious Medical Negligence Claims Plan

The core component of the Task Force recommendations is the proposal for Prompt Resolution of Meritorious Medical Negligence Claims.[15] This proposal is designed to address the following six goals:

1. Meritorious medical negligence claims should be distinguished from non-meritorious negligence claims at the earliest possible point.
2. Attorneys' fees and delay should be reduced.
3. Early settlement of claims should be facilitated.

4. Those making awards of damages should have more guidance, and awards of non-economic damages should be limited to reasonable amounts.
5. Outcomes of the claims resolution process should be more predictable, both to facilitate settlement and to allow insurance carriers to accurately determine their expected losses.
6. Either party's right to have its case heard by a jury should be preserved.

The figure on the next page provides a schematic representation of the operation of this proposal, its component parts and how they interrelate.

1. Prompt Investigation of Claims

This feature of the plan is intended to ameliorate two problems identified by the Task Force during its investigation of Florida's tort system:

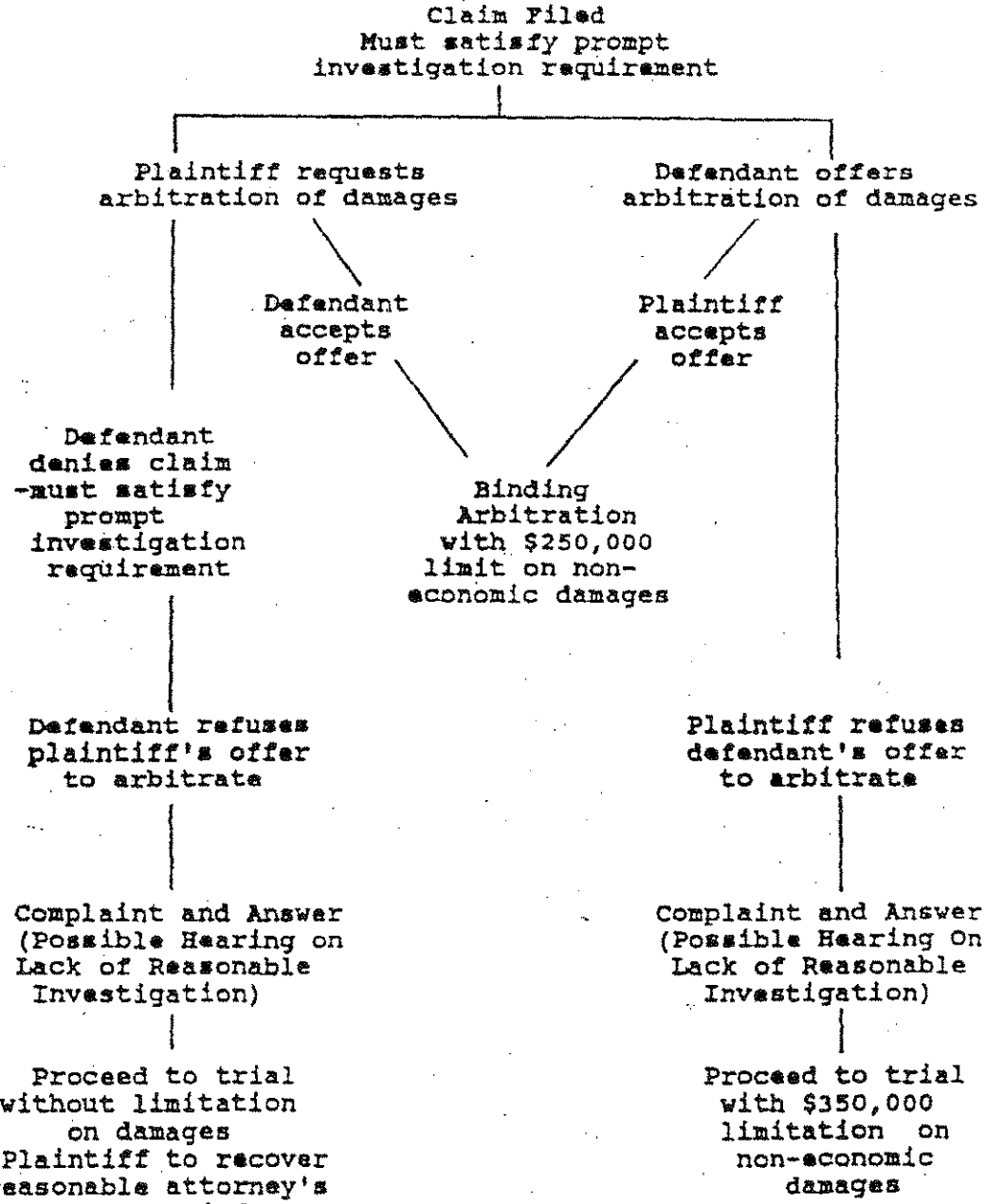
(1) the problems caused by clearly non-meritorious claims and defenses; and

(2) the frequent failure of the parties, particularly defendants, to prepare and evaluate their cases early in the process, thus resulting in considerable delay and expense.

The Task Force recommends that a claimant or claimant's attorney not be permitted to send a physician or other health care provider a Notice of Intent to Initiate Medical Malpractice Litigation pursuant to Florida Statute 768.57, unless the sending party has made a reasonable investigation to determine that there

SUMMARY

PROMPT RESOLUTION OF MERITORIOUS MEDICAL NEGLIGENCE CLAIMS



PROMPT RESOLUTION OF MERITORIOUS MEDICAL

NEGLIGENCE CLAIMS PLAN

RIGHTS OF PARTIES

	CLAIMANT REQUESTS ARBITRATION	CLAIMANT DECLINES ARBITRATION
DEFENDANT REQUESTS ARBITRATION	<u>Arbitration</u> -Defendant aggrees to pay damages -Full economic damages -Non-economic damages limited to $250,000 -Reasonable attorney's fees	<u>Jury Trial</u> -Plaintiff must prove negligence -Non-economic damages limited to $350,000
DEFENDANT DELCINES ARBITRATION	<u>Jury Trial</u> -Plaintiff must prove negligence -No limit on damages -Prejudgment interest -Reasonable attorney's fees	<u>Jury Trial</u> -Same rights and procedures as current system -Plaintiff must prove fault -No limit on damages

are reasonable grounds to believe that the physician or other health care provider has been negligent in the care or treatment of the claimant and such negligence has resulted in injury to the claimant. The claimant should be required to submit a written opinion of a qualified expert corroborating his claim of negligent injury at the time the Notice is filed.

The Task Force recommends that a corresponding duty be placed on the defendant or the defendant's insurer before the defendant is allowed to deny a claim. Within ninety days after receiving a Notice of Litigation, the defendant would be required to complete a reasonable investigation to determine whether reasonable grounds exist to believe that there has been no evidence of negligence or that any negligence that did occur did not contribute to the claimant's injuries. If the defendant files a denial of the claim, he would be required to accompany it with a written opinion of a qualified expert substantiating that there was no negligence or that the claimant's injuries did not result from the defendant's negligence.

This proposal would include procedures for allowing both the claimant and the defendant to have reasonable access to information within the possession or control of the other party in order to evaluate the claim.

Following the defendant's filing of a denial of a claim, either party may file a motion to have the court determine whether the opposing party's claim or denial rests on a reasonable basis. If the court finds that the claimant's claim was not preceded by a reasonable investigation, the claim would be dismissed and whoever filed the Notice of Claim (the claimant

or his attorney) would be personally liable for attorney's fees and costs, including the reasonable costs of the defendant or his insurer resulting from investigation and evaluation of the claim. Correspondingly, if the court finds that the defendant's denial of claim was without a reasonable investigation, it would strike the defendant's answer and whoever denied the claim (the defendant, his insurer, or his attorney) would be personally liable for the claimant's attorneys fees and costs, including the costs of preparation and investigation of the claim.

In the event that an attorney for the claimant is found to have filed a claim without reasonable investigation, or in the event that an attorney for a defendant is found to have filed a denial of claim without reasonable investigation, the Court would report the matter to the Florida Bar. Any attorney who is found to have filed more than three claims and/or defenses without reasonable investigation within a five year period would be investigated by the Florida Bar for possible disciplinary action. Any time that the court found that the written opinion of a physician, whether attached to a notice of a claim or a denial of claim, lacked reasonable investigation, such matter would be reported to the Board of Medicine or the appropriate successor agency described in these recommendations. Any physician who is found to have filed more than three written opinions without reasonable investigation, within a five year period would be investigated by the appropriate state agency for possible disciplinary action.

2. Early Offers and Arbitration of Claims

The next stage of proceedings under the Prompt Resolution of Meritorious Medical Negligence Claims allows the parties to elect to have the damages determined by an arbitration panel. Such damages should include full economic damages and non-economic damages determined in a more structured manner than jury awards and not to exceed $250,000. The advantage of this phase of the recommendation is that it promotes prompt resolution of claims and also provides the predictability necessary to encourage settlement in the legal system and to facilitate rate-making in the insurance system. It also limits potentially high awards for non-economic damages.

At the same time the claimant files a Notice of Intent to Initiate Litigation, he may accompany it with a request for arbitration of damages. After the defendant had been served with Notice, he also would have the right to request arbitration. If both parties accept arbitration, it would proceed as outlined in this section.

If the defendant agrees to arbitration of damages, this would be a binding commitment to pay the damages awarded by the arbitration panel, subject to any applicable policy limits. Defendant's commitment to pay such damages, either by making an offer to arbitrate or by accepting claimant's offer, would be for the purpose of arbitration only. If claimant rejected defendant's offer to arbitrate, the offer could not be used in evidence or in argument during subsequent litigation of the claim. Even if arbitration was accepted, the fact of making or

accepting the offer to arbitrate would not be admissible as evidence of liability in a collateral proceeding or any later proceeding on the same claim (in the event that arbitration broke down).

One arbitrator would be selected by the defendant, another by the plaintiff and the third by the previously selected two arbitrators. This proposal could include a requirement that every arbitration panel include one physician and one attorney.

The damages to be awarded by the arbitration panel would include net economic damages such as past and future medical expenses and 80 percent of wage loss, less collateral source payments. In addition, the claimant would receive recovery for loss of capacity to enjoy the amenities of life. These non-economic damages would be limited to a maximum of $250,000 and would be calculated on a percentage basis. For example, if the arbitration panel found that the claimant's injuries resulted in a fifty percent reduction in his capacity to enjoy life, it would award the claimant $125,000 non-economic damages. The defendant would be responsible for interest on all damages paid to the claimant accruing from a date 30 days after the claimant's original Notice of Intent. Finally, the defendant would pay the claimant's reasonable attorneys' fees and costs as determined by the arbitration panel. Any attorney's fees awarded to the claimant by the arbitration panel would be required to be offset against any contingent fee that the claimant has agreed to pay his attorney.

The arbitration panel would be authorized to provide for payment of any award of future economic loss through periodic or other structured payments. Upon death of the claimant, payments for future medical expenses would cease. The arbitrators could provide that payments for wage loss to the claimant's dependents would continue for a reasonable time after the claimant's death and then cease.

As between the insured physician and the insurance carrier, both the financial responsibility for payment of the arbitration award, and the control of the defense of the claim, including the decision of whether or not to arbitrate, would be determined under existing principles of Florida law.

If there are multiple defendants and all defendants agree to arbitration, then the amounts of claimant's damages would be determined as outlined above. After the arbitration panel has determined damages, the multiple defendants would submit any dispute among them regarding the apportionment of financial responsibility to a separate binding arbitration proceeding. This "allocation of responsibility" arbitration panel would be composed of physicians and other health care providers.

Payment by any defendant of the damages awarded by the arbitration panel and assessed against a particular defendant in the "allocation of responsibility" arbitration would extinguish its liability to the claimant. Also, such payment would extinguish the defendant's liability to a co-defendant arising from a subsequent contribution action. As described in the next section, the plaintiff would retain its full array of common law rights against any defendant not accepting arbitration. Any award

in the common law trial, however, would be reduced by the amount of damages recovered by the plaintiff from co-defendants following arbitration.

The Early Offer and Arbitration Procedure outlined here encourages the parties to avoid litigation of liability where appropriate and to narrow the issues as to the amount of damages. It provides a prompt mechanism for the determination of damages. The calculation of non-economic damages by an arbitration panel, on a percentage of impairment of claimant's ability to enjoy the amenities of life, produces greater predictability and stability than a jury determination of non-economic damages. This greater predictability encourages early settlement of claims in most cases. Finally, the $250,000 limit on non-economic damages serves to limit the high-end awards which the Preliminary Fact-Finding Report on the Medical Malpractice Report found to be a substantial factor in the dramatic increase in total paid losses; the increases in these losses, concluded the Task Force, were the primary cause of the dramatic increase in medical liability premiums.

3. Jury Trial With A Conditional Limitation on Non-Economic Damages

This section discusses the rights of plaintiffs and defendants to a jury trial under the Prompt Resolution of Meritorious Medical Liability Claims Plan. In all cases, either party may exercise its right to a jury trial.

If neither the claimant nor the defendant requests arbitration under this plan, the case would proceed to trial

under the current rules. The plaintiff would be entitled to his full array of rights under the existing common law tort system including the right to have the jury determine all appropriate damages. If the defendant does not offer to arbitrate and forces the plaintiff to prove liability and damages through the litigation process, the defendant should be fully responsible if the jury concludes that the defendant was negligent. Of course the plaintiff still may invoke the Demand for Judgment Procedures under current law which allow the plaintiff to recover attorney's fees and costs if the trial judgment exceeds plaintiff's settlement offer by more than 25 percent.

If the claimant requests arbitration of damages as outlined above, and the defendant refuses to submit to arbitration, then the plaintiff also is entitled to his full jury trial rights. In addition, the claimant should be able to recover his reasonable attorney's fees and prejudgment interest at the legal rate from the date that he requested arbitration. Any attorney's fees awarded to the claimant by the arbitration panel would be required to be offset against any contingent fee that the claimant owes his attorney. The claimant's rights to recover reasonable attorney's fees and prejudgment interest when he requests arbitration and the defendant refuses to arbitrate serve as additional financial incentives for both the claimant and the defendant to accept arbitration. Further, prejudgment interest acts as a disincentive for the defendant to delay in those cases which do proceed to trial.

If, on the other hand, plaintiff chooses not to accept a defendant's offer to have the damages determined promptly through arbitration, and to have plaintiff's reasonable attorney's fees paid by defendant, then the damages at the common law trial should be limited to full economic damages plus non-economic damages not to exceed $350,000.

The Task Force concludes that a conditional limit on non-economic damages is warranted after the plaintiff's refusal to accept the Early Offer of Arbitration. First, the conditional limit on non-economic damages at trial gives the plaintiff greater incentive to accept the defendant's offer to arbitrate. Second, the $350,000 limit on non-economic damages is an appropriate balance between the interests of all patients who ultimately pay for such losses and the interests of those patients who are injured as a result of medical negligence. The Task Force has found that the increase in paid losses is the primary cause of insurance affordability problems and that high-end awards are a substantial cause of the increase in paid losses. Further, insurers' concerns about the lack of predictability and the amounts of high-end awards have the potential for producing availability problems. On the other hand, this proposal, unlike the Medical Incident Compensation Act described below, recognizes that physical and mental pain and suffering are real.

The question is, given the inherent inefficiencies of the current tort system and its inexactitude in distinguishing meritorious claims from non-meritorious claims and full compensation from overcompensation, can society fully compensate

every claimant for all the non-economic damages that the jury might find appropriate in every medical liability case? The Task Force concludes that in the specific area of medical liability the answer is "no", just as the legislatures of at least thirteen other states, where malpractice insurance premiums are less than in Florida, have reached this conclusion. Unlike most other jurisdictions, however, the Task Force endorses this limitation only as a part of a package that includes carefully balanced proposals for eliminating non-meritorious claims from the system, reducing transaction costs, limiting actual medical negligence through increased regulation of the quality of medical care and providing equitable reductions in malpractice premiums for those physicians who can demonstrate genuine hardship as a result of high malpractice premiums.

This plan's conditional limitation on non-economic damages differs from the absolute cap that was held to be unconstitutional in Smith v. Department of Insurance.[16] First, it applies only to medical malpractice claims, where a special need has been established by specific research findings. Second, it is part of a balanced plan to facilitate early resolution of meritorious claims, thereby providing commensurate benefits in exchange for the reduced damage remedy. The $250,000 conditional limitation on non-economic damages applies only with the consent of both parties. The $350,000 limitation on non-economic damages applies only if the plaintiff has refused an opportunity to receive expedited payments of limited damages without having to prove fault.

B. Jury Instructions Providing Greater Guidance in Awarding Non-Economic Damages

The Task Force concluded in its Preliminary Fact-Finding Report on Medical Malpractice that the increases in the size of loss payments, both those resulting from court awards and those arising from settlements, were an important factor in the increase in medical malpractice insurance premiums. The Task Force anticipates, as a part of its Final Report due in March 1988, recommending that more specific jury instructions be provided to guide the jury in making awards of non-economic damages. These jury instructions would apply in all tort cases involving non-economic damages, but their effect would be especially significant in medical malpractice actions.

The primary function of juries is to make determinations of fact and the function of jury instructions is to assist juries in making fact findings that are consistent with the law. In the tort law, courts have traditionally had difficulty in setting down guidelines for measuring non-economic damages (i.e. pain and suffering, loss of amenities of life, etc.), especially those to be suffered in the future. In Florida and many states the basic rule is that juries are to use their collective good sense to make determinations that are fair, not biased, not inflamed by passion or prejudice, and not wholly outside the scope of the evidence. As guidelines, these standards prescribe what juries are not to do, but give little positive guidance as to what they should do.

Florida courts have long acknowledged the power of trial court judges to impose remittiturs or mistrials in the alternative, and the legislature has more recently encouraged courts to review awards thoroughly and has established specific guidelines to be used by courts in evaluating awards.[17] Nevertheless, these statutory review standards for the most part are limited to describing what juries may not do and do not adequately satisfy the need for affirmatively assisting juries in determining damages. The Task Force believes that better adherence to the compensatory goal of the tort law damages remedy may be achieved by the use of more specific jury instruction which directs the jury as to how it should award damages.

Standard jury instructions for actions in Florida's courts are promulgated by the Supreme Court's Committee on Standard Jury Instructions. The Task Force action in this regard, therefore, would not include recommendations to the Legislature; rather, the Task Force conclusions would be presented as suggestions for further attention by the Committee on Standard Jury Instructions.

The Task Force and its research staff anticipate further development of their suggestions in the month ahead. For now, the Task Force offers these preliminary observations to suggest to the Legislature how medical malpractice reform proposals might complement more specific jury instructions. Although the Task Force research staff has not fully developed a definite set of jury instruction guidelines, its proposes the following points as factors to be considered if this approach is to be followed and further developed:

1. Non-economic damages are an element of compensatory damages. The law has no inherent curative capacity, but can only award damages that provide tangible substitutes of equivalent value to the plaintiff for the non-economic losses suffered. The fact that monetary damages cannot undo the harm to the plaintiff does not justify unlimited jury discretion in fixing the amount of the award.

2. Non-economic damages should not include any additional damages awarded for the purpose of punishing the defendant or to make an example of bad behavior. The sole goal of compensatory damages is to make the plaintiff whole for what has been lost.

3. Non-economic damages must not include sums for lost earnings or medical and rehabilitative expenses. These are considered to be economic losses, and the jury must award them under the economic damages category and must take great care not to compensate the plaintiff a second time for the same losses by adding extra increments to the non-economic damage award for that purpose.

C. No-Fault Plan for Birth-Related Neurological Injuries

In its Preliminary Fact-Finding Report on Medical Malpractice, the Task Force found that obstetricians were among the physicians most severely affected by current medical malpractice problems. Obstetricians were more likely than other physicians to have claims filed against them, their malpractice

premiums were among the highest and the recent increases in malpractice premiums for obstetricians were greater than for other physicians. The Fact-Finding Report specifically noted that in today's society, anything other than a normal birth is considered an aberration and often leads to a claim against the obstetrician.

To remedy these problems, the Task Force recommends adoption of a no-fault compensation plan for birth related neurological injuries, similar to the plan adopted under a 1987 Virginia statute. The Task Force endorses this separate treatment for birth related neurological injuries for two reasons: first, because claims costs in this area have been particularly high, and, second, because a no-fault system in this limited area is feasible and would involve manageable costs.

For other types of medical injury, the Task Force does not recommend a no-fault compensation alternative to the tort system. This negative conclusion is compelled by findings that a comprehensive no fault system for all medical injuries would be prohibitively expensive, many times more expensive than the existing medical malpractice systems. In order to develop a no-fault system at reasonable cost, it is necessary to establish a framework for distinguishing compensable events from non-compensable events. In most areas of medical injury, this is not economically feasible at the present time. For example, defining the compensable event for a no-fault plan to cover medical injuries in emergency rooms and trauma centers would require terms broad enough to include injuries of every degree to any part of the body resulting from an unlimited variety of medical

interventions. Because of its expansive potential, such a broad definition of the compensable event would make no-fault insurance costs prohibitively expensive, at worst, and impossible to predict, at best.

A feasible structure for determining compensable events in birth-related neurological injuries does exist, as demonstrated by the Virginia statute which is attached as Appendix A to these recommendations. The Task Force recommendation, based upon the Virginia plan, would provide immediate compensation, on a no-fault basis, for a very limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation. The statute would define these injuries in terms of "injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living."

The Virginia statute does not take effect until January 1, 1988, so that actual experience under the statute is not yet available. However, enactment of the plan has already produced noticeable results in terms of improved availability and affordability of liability insurance coverage for obstetricians in Virginia.

Full details of the plan will not be presented here, because a well-developed statute is available for a model. A copy of the

Virginia statute is attached as an Appendix. The essential features of the plan are as follows:

1. Establish a no-fault compensation fund to provide life-time care of infants with severe birth-related neurological injuries; compensation limited to net economic losses.

2. No-fault benefits would be the exclusive remedy for injuries suffered by infants covered by the plan.

3. Claims for statutory compensation benefits must be heard within 120 days by an administrative agency (the Division of Workers' Compensation, in Florida).

4. Voluntary participation by hospitals and by physicians who practice obstetrics; initial fee of $5,000 for participating physicians, $50 per delivery for participating hospitals, and assessment of $250 for all other physicians; annual fees thereafter on actuarial basis.

5. Deficiency assessment against all liability insurance carriers in the state, if the fund becomes inadequate.

6. Participating physicians and hospitals must agree to submit to review for disciplinary or regulatory purposes in any case where substandard care is indicated.

The Virginia statute does not require participating physicians and hospitals to give notice to obstetrical patients that they are participating in the limited no-fault alternative for birth-related neurological injuries. The Task Force recommends that health care providers who participate under this plan should be required to provide reasonable notice to patients of their participation. This notice requirement is justified on fairness grounds and arguably may be required in order to assure that the limited no fault alternative is constitutional.

D. Negative Recommendations

The Task Force has considered all of the options described in the Discussion Draft of Medical Malpractice Reform Alternatives, dated October 2, 1987. The Task Force has decided to endorse only those proposals that are specifically recommended in this report, and it does not endorse any of the other alternatives that were reviewed in the Discussion Draft.

The Task Force does not recommend adoption of the Medical Incident Compensation Act.[18] This plan would require the claimant to prove medical negligence, but it would eliminate the claimant's right to recover non-economic damages and would limit economic losses to scheduled economic benefits including a restricted percentage of proven wage loss. It would also eliminate the claimant's right to a jury trial in all cases. The plan could not be legislatively implemented without a constitutional amendment.

The Medical Incident Compensation Act would probably reduce medical malpractice liability loss payments, but such reductions would be achieved exclusively by reducing the rights of claimants. The plan would do nothing to facilitate separating meritorious from non-meritorious claims and it would provide no increased incentives for the prompt resolution of meritorious claims.

The Task Force does not endorse a proposed constitutional amendment that would limit non-economic damages to $100,000 in all cases, including medical liability cases. Once again, any cost savings from this proposal would be achieved solely by penalizing the most seriously injured victims who already have proven negligence in a court of law. Unlike the conditional limit on non-economic damages that is a part of the Prompt Resolution of Meritorious Medical Negligence Claims proposal, the cap standing alone does nothing to distinguish meritorious from non-meritorious claims, to reduce attorneys' fees and other transaction costs, to encourage early settlement or to reduce tortious injuries in the first place. Moreover, the Task Force believes that the $100,000 cap is too low a figure and removes recovery for legitimate damages in many cases without providing offsetting benefits for plaintiffs. No other state limits non-economic damages to such a low figure in all types of cases. The Task Force recognizes that problems in the medical liability system are substantially more severe than in most other areas of the tort and liability insurance systems. Legitimate concern about malpractice premiums and medical liability payments should

not be translated without further study into major revisions of the entire tort system.

The Task Force is making no recommendation at this time on the issue of whether periodic payment of future economic damages should be mandatory. The Tort and Insurance Reform Act of 1986 authorizes the court to order periodic payments of future economic damages in excess of $250,000,[19] but does not require the court to do so. Making periodic payments of future economic damages mandatory for court awards might produce substantial insurance cost savings. The Task Force, however, declines to make a recommendation to the Legislature at this time for two reasons. First, the Task Force and its research staff have not had the opportunity to fully evaluate the effectiveness of any potential changes in Florida law governing periodic payment of future economic damages. Further, any changes to the statute should apply to all tort cases, not just medical malpractice ones. Accordingly, this issue will be addressed in the Task Force Final Report to the Legislature.

II. PROFESSIONAL REGULATION

This section includes the Task Force proposals for reducing the costs of the medical liability system by reducing actual medical negligence and other medical accidents in the first place. The Task Force does not believe that recent increases in loss payments result from a deterioration in the quality of medical care in Florida. Nonetheless, any reduction in actual medical negligence will tend to reduce the number of medical malpractice claims. In addition, aside from the problems with the affordability of medical liability insurance, improving the quality of medical care is a desirable public policy goal and one that the Task Force believes is attainable.

Strengthened regulation of medical care providers is not a substitute for tort and insurance reform, but does complement other reforms. The Task Force does not believe that the Legislature is faced with a choice between civil justice reform and strengthened regulation of physicians. Rather, effective reform must include both.

The Task Force makes three separate recommendations involving professional regulation of health care providers. First, state regulation of health care providers must be substantially strengthened. This more effective state regulation should include not only more adequate funding from the Legislature, but also a commitment by state regulatory authorities to take seriously their obligation to discipline health care providers whose incompetence or inattention results in medical injuries. Second, the Task Force believes that this

heightened regulation of the medical professional can be accomplished best by creation of a new, specialized state division, the Division of Medical Quality, within the existing Department of Prfessional Regulation, with comprehensive responsibility to investigate, prosecute, and decide disciplinary actions against health care providers, and to provide standards for the licensing of health care providers. Third, the Task Force recommends that the state health care regulatory agency should assume greater responsibility for medical professional discipline and quality assurance at the local level. Local boards should be established to identify discipline and competency problems earlier and to coordinate peer review and quality assurance programs conducted by local medical societies and hospitals.

A. Strengthened Regulation of Health Care Providers

The need for strengthened state regulation of health care providers is widely acknowledged.[20] The Task Force found, in its Preliminary Fact-Finding Report on Medical Malpractice, that disciplinary proceedings against physicians in Florida were rare events compared to paid medical malpractice claims. Between 1982 and 1986 a total of 2,696 Florida physicians had paid closed claims for medical malpractice actions. Of this total, 366 physicians had two or more paid claims.[21] Over the longer period from 1975 to 1986, closed claim analysis revealed that the 4 percent of the physicians with two or more paid claims were responsible for 42 percent of the amount of paid claims.[22] The

Preliminary Fact-Finding Report noted that multiple claims did not necessarily indicate a "bad doctor," but suggested that more effective regulation of certain health care providers could decrease the amount of indemnity payments.

In contrast, the disciplinary records of the Department of Professional Regulation (DPR) reveal that relatively few health care providers are disciplined because of concern about competency or repeated malpractice. During the period from 1975 to 1987, DPR indicated that the total number of disciplinary actions against physicians was 729.[23] DPR uses a category for record keeping purposes which does not distinguish cases involving actual incompetence or malpractice from other grounds for disciplining such as substance abuse or prescribing irregularities. Only 32 percent of DPR disciplinary proceedings against physicians fall into this generic category,[24] and most of these actions are not for medical malpractice or incompetence. A reasonable estimate would be that the number of DPR disciplinary actions for incompetence and negligence is about two percent of the number of paid medical negligence claims and less than one-sixth the number of physicians with multiple paid claims. This analysis suggests empirically the need for heightened regulation of health care providers.

State regulation of health care providers involves authority over both professional licensing and disciplinary processes. The Task Force recommendations for strengthening quality assurance mechanisms are presented in the next two subsections of this report. Regarding physician licensing requirements, the Task Force recommends evaluation to determine whether existing

criteria for both initial and renewal medical licensure should be tightened. Specifically, the licensing agency should consider the desirability of increasing the residency training requirement from the current one year requirement to a two or three years requirement.[25] Many hospitals already require more lengthy training requirements as prerequisites for hospital staff privileges. In addition, the state licensing authorities should consider the desirability of increasing the continuing medical education requirements for practicing physicians and instituting periodic relicensure examinations.[26] In this context, periodic re-testing of basic skills would help assure ongoing competency of practicing physicians and provide a focus for continuing medical education programs.

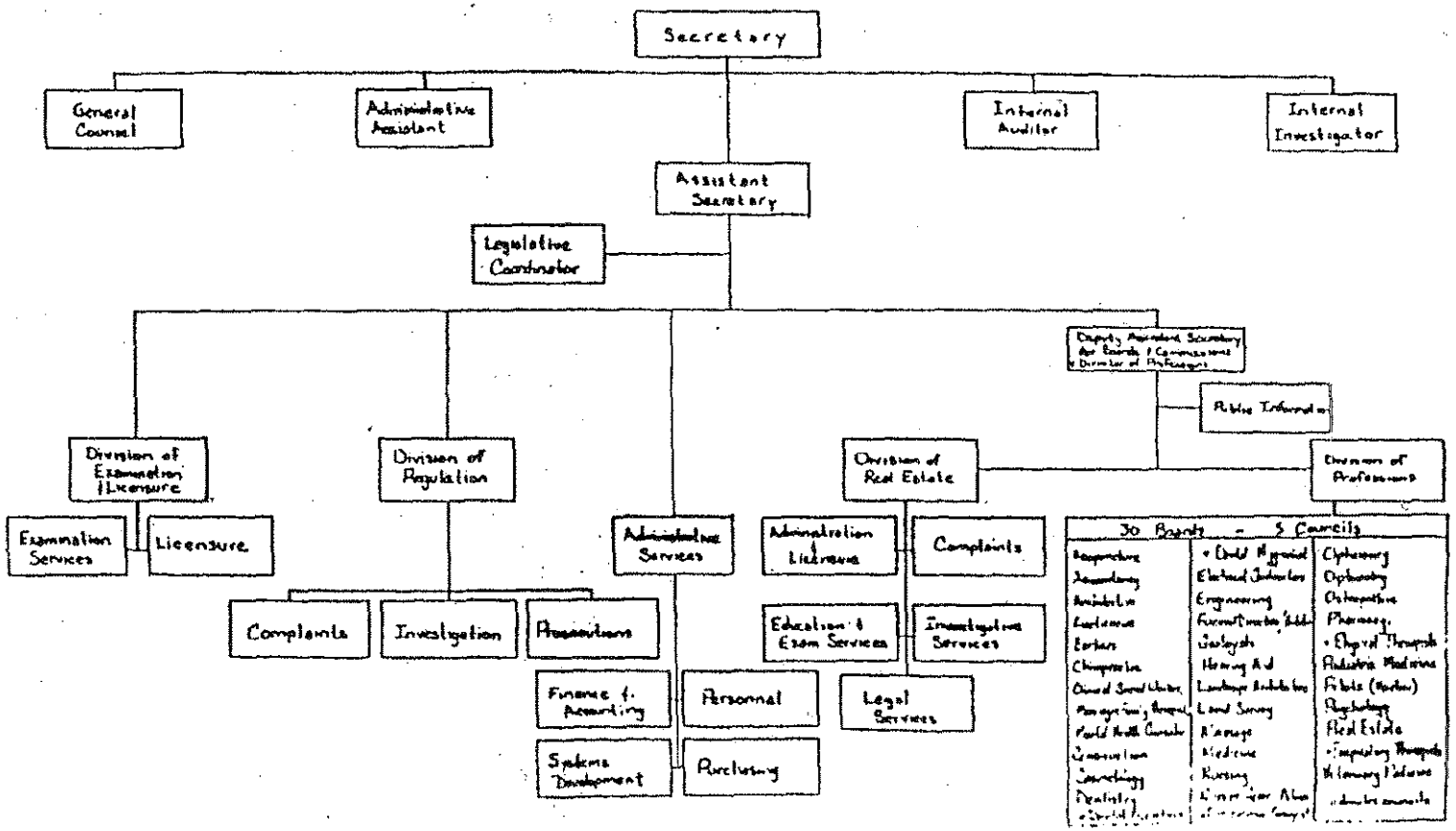
B. Creation of a Specialized Division Within the Department of Professional Regulation.

The discipline and licensing of health care providers currently is handled within the Department of Professional Regulation. The primary responsibility within the agency for health care providers rests with the Board of Medicine, but certain licensure, investigation and prosecution functions, as well as administrative services, are provided by separate divisions. A current organizational chart for the Department of Professional Regulation is provided on the next page.

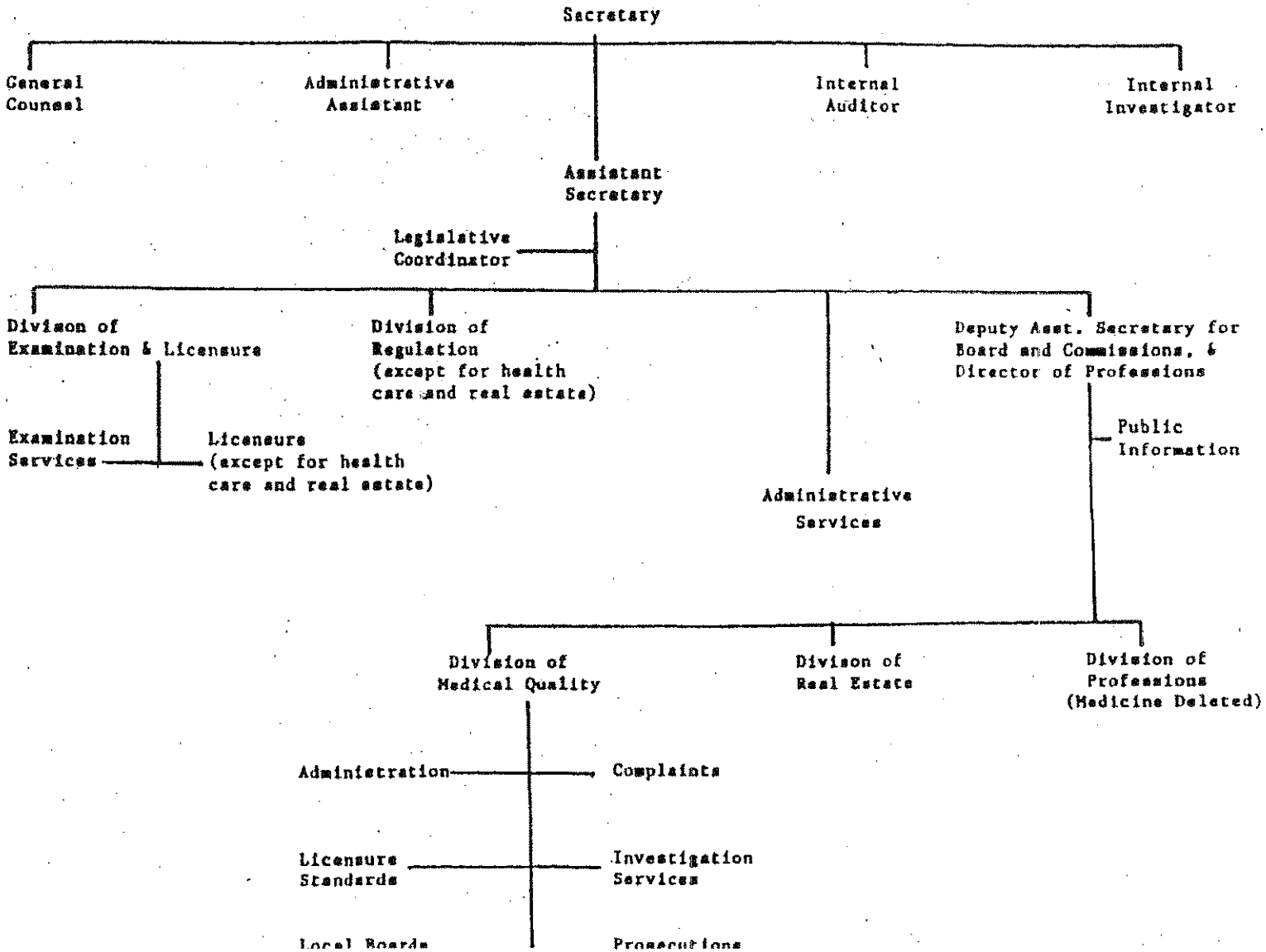
The Task Force recommends the establishment of a separate and specialized "Division of Medical Quality." This Division of Medical Quality would assume the functions currently handled by

Existing Organization

Department of Professional Regulation



Proposed Organization
DEPARTMENT OF PROFESSIONAL REGULATION



the Board of Medicine, as well as the functions currently handled by other divisions of the Department of Professional Regulation, in so far as those functions relate to health care providers. Funding for the new Division of Medical Quality would be appropriated specifically for use by this Division and would come in part from increases in professional licensing fees for health care providers.

The specialized division should include a board consisting of both physician and public members. Physician members would be nominated by the medical professional societies (e.g., the Florida Medical Association), subject to approval by the governor and the public members would be appointed by the governor. Public members could include representatives of the legal profession, hospitals, and allied health concerns (e.g. nurses and pharmacists).

A specialized division within the Department of Professional Regulation would improve the current system in several ways. An independent agency would be able to develop the specialized regulatory and investigatory expertise needed for effective health care regulation. Additionally, cooperation between local provider physicians and the regulatory agency would be enhanced by an identifiable division in which physicians have confidence. The Task Force's survey of Florida physicians revealed that only 18 percent of physicians characterized the current professional regulatory mechanisms as adequate.[27]

The Task Force recommends that any increased costs of the health care regulatory division be borne primarily by professional licensing fees. Existing licensing fees are

relatively low ($50.00 per year for renewal fees) when compared to other physician expenditures such as professional society dues and professional publications. An increase in the annual renewal license fee to the range of $200 with proportionate increases in other licensing fees would create substantial revenues for operation of a regulatory division with enhanced responsibilities.

C. A Comprehensive Plan for Quality Assurance and Professional Discipline at the Local Level

The Task Force recommends that legislation be enacted that requires the state health care regulatory division to assume greater responsibility for medical professional discipline and quality assurance at the local level. The division should establish local quality assurance boards to identify health care provider competency and disciplinary problems at their source and to coordinate with peer review and quality assurance programs conducted by local medical societies and hospitals.

Perhaps the greatest challenge for a centralized state division regulating the quality of health care is to identify physicians and other health care providers who are providing inadequate health care. The ideal method of identifying a potential health provider competency problem is at the local level before serious consequences result. It is in this area that the current regulatory system experiences the greatest difficulty. Providing the degree of desirable local oversight without help from the private sector seems impossible. It would require a pervasive state presence in local medical practice

that would be difficult to fund and would result in excessive intrusion by the state into professional activity.

Legislation establishing closer ties between state health care regulators and local health care providers is required if potential malpractice by physicians is to be discovered in time to prevent recurring medical accidents. The state's supervisory and sanctioning authority should work in tandem with the private sector's day to day knowledge of potential problem areas. Individual hospitals and professional societies already carry out internal peer review and quality assurance programs. The Task Force recommends that the state regulatory authority assume a direct supervisory and coordinating role among these independent private quality assurance programs.

Specifically, the health provider regulatory division should establish grievance committees on a county or district basis with the assistance of local medical societies. Physician members of the local boards would be selected from the local professional societies, and support staff would be provided by the state regulatory division. These local committees would provide the initial evaluation of health care provider competency and disciplinary problems. The committees would initiate investigations of local health care providers in several circumstances, including consumer complaints and triggered review of medical malpractice claims. Additionally, hospital peer review and quality assurance committees would be required to report all hospital recommendations for discipline and privilege restriction to the local committees for further evaluation.

After initial investigation and evaluation the committee would forward all documentary evidence as well as a written evaluation, including findings and recommendations, to the central state division. Investigations that result in findings of no valid grounds for disciplinary action would be reviewed for abuse of discretion by the division to assure the integrity of the process. Any recommendation for further disciplinary action would be reviewed by the full disciplinary committee of the division. All final disciplinary orders would issue from the state division.

Discovery of potential competency problems at the local level at an earlier point would allow for a wider range of remedial actions than typically are used under the existing system. Many problems will not require license suspension or revocation. Instead, specifically tailored remedies such as supervised practice, mandated additional training or prohibitions from performing particular procedures will be appropriate in many instances.

The individual health care provider would be guaranteed full due process rights through division procedures and final appeal to a district court of appeal, at the same time that the public interest is protected. The "clear and convincing evidence" standard for disciplining professionals which currently exists would be changed to a less onerous "preponderance of the evidence" standard.

Good faith participants in the process of investigating and disciplining health care providers should receive statutory immunity from retaliatory tort suits. In addition, participants

in disciplinary process should be protected from federal antitrust suits filed under the Sherman Act. In such cases, the plaintiff usually sues the reviewing physicians individually, as well as the hospital and its administrators. The prospect of having to defend such suits discourages physicians and other health care providers from participating in disciplinary proceedings. Antitrust immunity can be provided under the state action (Parker) doctrine provided that (1) the state expresses its policy choice in an affirmative and clearly articulated fashion and (2) the state actively supervises any resulting private power that could be used in an anticompetitive way.[28] Accordingly, the research staff recommends that the establishment of the disciplinary procedures outlined here include the provisions required to shield participants in the disciplinary procedures from antitrust suits.

III. REDISTRIBUTION OF INSURANCE COSTS

The research conducted by the Task Force and reported in the Preliminary Fact Finding Report on Medical Malpractice established that, in some cases, escalating medical malpractice liability insurance premiums "... represent an increasing financial burden to physicians, with significant variation seen between medical specialties." Moreover, there may be a diminished opportunity for physicians to pass on higher business costs with the result that malpractice liability insurance has become "functionally unavailable" for some physicians in the state. As a result, some physicians have responded in ways that have resulted in either the complete or partial withdrawal of needed medical services. The Task Force recommends the Premium Impact Equity Plan, outlined in this section, to provide immediate relief for those physicians who can demonstrate that malpractice premiums are causing special financial difficulties.

A. Risk Class Compression Plans: A Negative Recommendation

Most proposals to provide physicians with rate relief, including the three proposals discussed in the Discussion Draft on Medical Malpractice Reform Alternatives, involve risk class compression as a means to bring down the premiums for the highest risk classes. The Task Force believes that such approaches are unnecessarily costly and that they would provide an inequitable remedy for any genuine affordability problems caused by medical liability insurance.

Mandatory risk class compression plans would require charging low risk physicians more than actuarially sound premiums in order to subsidize lower than actuarially sound premiums for high risk practitioners. Often these high risk practitioners also earn high incomes, and the Task Force believes that subsidies for high income physicians are not justified. Routine subsidization of physicians with high premiums, regardless of need or equity, would result in premiums for low risk physicians, and costs to their patients, that are higher than those actuarially sound and higher than those that are warranted by the genuine financial difficulties of a few high risk physicians.

Mandatory risk class compression proposals would also require increased state intrusion into the operation of the private insurance market. One prominent proposal would establish a state operated insurance pool to provide the mandatory first layer of malpractice liability insurance. The Task Force believes that such a state operated pool could effectively destroy any existing vitality and competitiveness in the private market for medical malpractice insurance in the state of Florida. Neither the market that would exist for private insurance to provide excess coverage above the limits offered by the state pool nor the prospect that the state operated pool would be a temporary measure is enough, in the opinion of the Task Force, to prevent a state mandated pool from severely impairing the private market in Florida.

For these reasons, the Task Force recommends against any state mandated risk class compression plan.

B. Subsidization With General Tax Revenues: A Negative Recommendation

Other proposals that have been advanced, and which were considered in the Discussion Draft, would use general tax revenues to subsidize physicians with high malpractice premiums. The Task Force opposes using general state revenues to subsidize malpractice premiums, particularly those of physicians who may be "high premium," but also high income, physicians.

C. The Premium Impact Equity Plan

Instead of a risk class compression plan or subsidization using general state revenues, the Task Force recommends adoption of the "Premium Impact Equity Plan". This plan avoids the pitfalls of subsidizing many high risk physicians who really do not need subsidies and also does not damage the private market for medical liability insurance in Florida. At the same time, it is a cost effective method to provide immediate relief to those high premium physicians experiencing genuine financial difficulties during the next several years, as the other reforms outlined in these recommendations have time to begin to control loss payments and to provide greater efficiencies in the tort system.

This plan would provide selective relief to physicians who affirmatively establish that their medical malpractice liability insurance premiums represent a financial burden. The plan would be financed and effectively controlled by physicians and would sunset at the end of five years.

1. Eligibility

The Premium Impact Equity Plan is designed to provide financial relief to any full-time physician who affirmatively demonstrates the following:

(1) The physician's medical malpractice premiums exceed a specified percentage of gross revenues, e.g., fifteen percent of gross revenues;

(2) The physician's net income from the practice of medicine is less than a specified amount, e.g., $75,000.

(3) The physician is not being charged a higher malpractice premium because of a surcharge resulting from past medical malpractice paid claims, past disciplinary proceedings or other factors suggesting that he or she as an individual is a "bad risk."

The fifteen percent of gross revenues threshold and the $75,000 of net income threshold are included for illustrative purposes only. Further analyses of these levels and the amount of revenue available to fund this program are necessary before final threshold numbers can be established.

The threshold criteria permit equity payments to be made to physicians in all specialties in all parts of the state. Thus, a general practitioner in a northern, rural part of the state and a neurosurgeon in South Florida both may be eligible. This feature is not present in a risk class compression plan. The latter simply reduces premiums for high risk classes and makes up the

lost revenue by increasing the premiums for lower risk classes. Risk compression plans are both over inclusive and under inclusive: they provide rate relief to physicians who do not need it and may exclude financially burdened physicians.

Eligibility under this plan also is restricted to those physicians whose current malpractice premium does not include a surcharge for claims experience, past disciplinary proceedings or other factors suggesting that he or she individually (as opposed to practicing in a high risk specialty) is a "bad risk." To subsidize surcharges resulting from medical negligence would contradict other aspects of this overall plan.

Only full-time practitioners would be eligible under this plan. For example, physicians who are beginning to retire by gradually reducing the size and extent of their practice to a part-time basis would not be eligible. The burden of proof to establish full-time practice would fall upon the physician.

2. Benefits

Eligible physicians would be entitled to request a premium impact equity payment in an amount sufficient to bring the percentage of gross practice revenue represented by the malpractice premium down to the threshold figure. In the example above, a physician whose malpractice premium was 19 percent of gross revenue and whose net income was less than $75,000 would be entitled to an amount equal to 4 percent of gross revenues. If such an amount would increase net income above the trigger point (in this case $75,000), then the physician would only be entitled

to the benefits necessary to bring his or her net income up to $75,000.

3. Financing

This program would not involve existing state revenues and would be funded by a tax on medical malpractice liability insurance premiums. All types of insuring organizations which provide medical malpractice liability insurance for physicians would be subject to the levy. This would include, but is not necessarily limited to, commercial insurers, the Florida Medical Malpractice Joint Underwriting Association, self-insurers, and risk retention groups.

Medical malpractice premiums in Florida for the year 1987 are roughly $300 million dollars. Although the portion paid by physicians is unknown because the figure includes amounts for nurses, chiropractors and other groups not included in this plan, the bulk of these premium dollars is probably paid by physicians. If physicians' premiums totaled $250,000,000, then each percentage point of a tax would generate $2,500,000 for the program. The amount of funds needed to finance the plan would depend upon the benefits provided. Physicians would play a prominent role in the administration of the program, as described below, and would have considerable discretion in determining the eligibility limits for both the net income threshold and the premium percentage threshold.

The surcharge on premiums would be collected by each insuring organization and remitted directly to the agency in charge of physician supervision and regulation. The funds would

be maintained in a separate account and would not be available for any purposes other than the disbursement of equity payments and the administration of the program.

In the event of a deficit, general revenues would be used temporarily to cover the shortfall. In determining the premium tax for the following year, however, the plan would collect sufficient funds to provide current year equity payments and to reimburse general revenues for the amount of the previous year's deficit plus interest.

4. Management

This program would be managed by the state agency responsible for the supervision and regulation of physicians. As discussed previously, this agency would be managed by a board consisting of physicians elected by Florida physicians and approved by the Governor, and public members appointed by the Governor.

The Board or its designee would determine the eligibility of a physician applying for equity payments. Because eligibility is measured against specific quantifiable standards, the possibility for dispute as to eligibility is reduced. The burden would be on the physician to establish eligibility under all criteria by clear and convincing evidence. Submission of federal tax returns for the previous year would be required. This review of the physician's affairs is warranted by the physician's voluntary decision to apply for a premium equity payment. Physicians are not required to disclose income data unless they choose to apply

for the equity payment. Any income or losses not attributable to the practice of medicine would be excluded in the determination of eligibility.

The Board should periodically review the eligibility limits.

5. Termination of the Program

The Task Force recommends that the Legislature review this program five years after adoption to determine the need for continuing the program. As the other reforms contained in this package control future loss payments, future malpractice premium increases should be reduced and premiums as a percentage of physician gross revenues should stabilize and possibly decline. In addition, as noted in the Preliminary Fact-Finding Report on Medical Malpractice, the dramatic acceleration in increases for medical malpractice premiums was a contributing factor to Florida's malpractice problems. Because the premium increases occurred so quickly, some physicians may not have been able to pass these increased costs immediately through to patients. It is likely that in the years ahead physician net income will continue to increase, thereby reducing the need for this program.

6. Summary

The Task Force believes that some temporary redistribution of the costs of medical malpractice liability insurance is desirable in order to ensure the continued delivery of needed medical services in the state of Florida and to encourage physicians to continue to practice in critical high risk specialties. This redistribution should be based upon the

following principles: a) administrative costs (both private and public) should be minimized, b) loss cost allocation should continue to be determined by the private sector in a competitive market subject to regulatory review, c) risk class determination should be on an actuarially sound basis and d) physician malpractice loss costs should be borne by physicians.

Based upon the above-stated goals, the Task Force recommends the adoption of the "Premium Impact Equity Plan". Unlike general risk class compression plans, the equity plan targets premium relief to financially burdened physicians in any part of the state and in any medical specialty. The cost of this program is appropriately borne by physicians rather than shifted to some other group.

While shifting a portion of physician malpractice costs to hospitals would probably result in desirable loss control incentives, the Task Force is concerned about the ability of hospitals to absorb such increased costs. Finally, general cost shifting of physicians malpractice costs to the citizens of Florida, either through the Medical Malpractice Joint Underwriting Association or through general taxation, would be an unnecessary subsidy of all high risk physicians, including ones that do not need it, by all the residents of Florida regardless of financial circumstances.

Footnotes

[1] Tort and Insurance Reform Act of 1986, chapter 86-160 (1986).

[2] Other proposals for addressing Florida's medical malpractice problems are outlined briefly in the Discussion Draft of Medical Malpractice Reform Alternatives (October 2, 1987) prepared by the research staff of the Academic Task Force for Review of the Insurance and Tort Systems.

[3] FACT-FINDING REPORT, 3 (Major Finding #3).

[4] FACT-FINDING REPORT, 36 and 239-240.

[5] ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS, PRELIMINARY FACT-FINDING REPORT ON INSURANCE AND TORT SYSTEMS, 33 (September 25, 1987).

[6] FACT-FINDING REPORT, 4 (Major Findings 3, 4 and 6), 7-10, 44-96.

[7] FACT-FINDING REPORT, 4 (Major Findings 8 and 9), 110-136.

[8] FACT-FINDING REPORT, 133-136.

[9] FACT-FINDING REPORT, 5 (Major Finding 14) and 190-198.

[10] FACT-FINDING REPORT, 5 (Major Finding 11).

[11] FACT-FINDING REPORT, 27-31, 117.

[12] PRELIMINARY FACT-FINDING REPORT ON INSURANCE AND TORT SYSTEMS (Draft), 266 (September 25, 1987).

[13] FACT-FINDING REPORT, 142-146.

[14] FACT-FINDING REPORT, 231-232.

15 An earlier version of the proposal was designated the "Prompt Investigation/Early Offer Proposal" in the Discussion Draft and considered on pages 23-25 of that draft.

16 Smith v. Dept. of Insurance, 507 So.2d 1080 (Fla. 1987).

17 See e.g. Fla. Stat. §768.74 (1986 Supp.)

18 See DISCUSSION DRAFT, MEDICAL MALPRACTICE REFORM ALTERNATIVES, 35-37 (October 2, 1987).

19 FLA. STATE. § 768.78 (1986).

20 See, Report on the Special Task Force on Professional Liability Insurance and the Advisory Panel on Professional Liability, 257 JAMA 810, 811 (1987); Kusserow, Handley & Yessian, An Overview of State Medical Disciplina, 257 JAMA 820, 822 (1987); Breaden & Galusha, State Medical Boards, 312 NEJM 784, 785 (1985); Wolfe, Bergman & Silver, MEDICAL MALPRACTICE: THE NEED FOR DISCIPLINARY REFORM, NOT TORT REFORM, PUBLIC CITIZEN RESEARCH GROUP REPORT (1985).

21 FACT-FINDING REPORT, pp. 231-232.

22 FACT-FINDING REPORT, 144-147.

23 FACT-FINDING REPORT, 231.

24 FACT-FINDING REPORT, 232.

25 Connecticut, Maine, New Hampshire, and Washington require two years of residency training before licensure. Nevada requires three years. Osteen, Medical Licensure Requiremtns, 258 JAMA 1053 (1987).

26 Currently, physicians must complete forty hourse of continuing medical education every two years. FLA. STAT § 453.213 (5) (1986 Supp.).

[27] FACT-FINDING REPORT, 253.

[28] "State action" exemptions from Federal antitrust can be traced to Parker v. Brown, 317 U.S. 341 (1943); See also, Town of Hallie v. City of Eau Claire, 455 U.S. 40 (1985); California Retail Liquor Dealers Asson v. Midcal Aluminum, 455 U.S. 97 (1980).

1987 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 540

An Act to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 50 consisting of sections numbered 38.2-5000 through 38.2-5021, establishing the Birth-Related Neurologicial Injury Compensation Act.

[H 1216]

Approved Mar 27 1987

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 38.2 a chpater numbered 50, consisting of sections numbered 38.2-5000 through 38.2-5021, as follows:

CHAPTER 50
VIRGINIGAL BIRTH-RELATED NEUROLOGICAL INJURY
COMPENSATION ACT.

§ 382.5000. Short title.-The provisions of this chapter shall be known and may be cited as the Virginia Birth-Related Neurological Injury Compensation Act.

§ 38.2-5001. Definitions.-As used in this Act:

"Birth-related neuroligcal injury" mean injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living. This definition shall apply to live births only.

"Claimant" means any person who files a claim pursuant to § 38.2-50004 for compensation for a birth-related neurological to an infant. Such claims may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claims may be filed by an administrator, executor, or other legal representative.

"Commission" means the Industrial Commission of Virginia.

"Participating physician" means a physician licensed in Virginia to practice medicine, who practice obstetrics or performs obstetrical services either full or part time and who at the time of the inury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the physician agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the State Board of Medicine whereby the physician agreed to submit to review by the Board of Medicine whereby the physician agreed to submit to review by the Board of Medicine as required by subsection B of § 38.2-5004, and (iii) had paid the assessment required pursuant to this chapter for the year in which the injury occurred.

"Participating hospital" means a hospital licensed in Virginia which at the time of the injury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the hospital agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the State Departmetn of Health whereby the hospital greed to submit to review of its obstetrical service, as required by subsection C of § 38.2-5004, and (iii) had paid the assessment required pursuant to this chapter for the year in which the injury occurred.

"Program" means the Virginia Birth-Related Neurological Injury Compensation Program established by this chapter.

§ 38.2-5002. Virginia Birth Related Neurological Injury Compensation program; exclusive remedy,; exception.-A. There is hereby established the Virginia Birth-Related Neurological Injury Compensation Program.

B. The rights and remedies herein granted to an infant on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, his personal representative, parents, dependents or next of kin, at common law or otherwise arising out of or related to a medical malpractice claim with respect to such injury.

C. Notwithstanding anything to the contrary in this section, a civil action shall not be foreclosed against a physician or a hospital where there is clear and convincing evidence that such physician or hospital intentionally or willfully caused or intended to cause a birth-related neurological injury, provided that such suit is filed prior to and in lieu of payment of an award under this chapter. Such suit shall be filed before the award of the Commission becomes conclusive and binding as provided for in § 38.2-5011.

§ 38.2-5003. Industrial Commission authorized to hear and determine claims.-The Industrial Commission is authorized to hear and apss upon all claims filed pursuant to Chapter 2 (§ 65.1-10 et seq.) of Title 65.1 of this Code as necessary to carry out the puposes of this chapter.

§ 38.25004. Filing of claims; review by Board of Medicine; review by Department of Health; filing of responses.-A.1. In all claims filed under this chapter, the claimant shall file with the Commission a petition, setting forth the following information:

a. The name and address of the legal representative and the basis for his representation of the injured infant;

b. The name and address of the injured infant;

c. The name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred;

d. A description of the disability for which claim is made;

e. The time and place where the injury occurred;

f. A brief statement of the facts and circumstances surrounding the injury and giving rise to the claim;

g. All available relevant medical records relating to the person who allegedly suffered a birth-related neurological injury

and an identification of any unavailable records known to the claimant and the reasons for their unavailability;

h. Appropriate assessments, evaluations, and prognoses and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of a birth-related neurological injury;

i. Documentation of expenses and services incurred to date, which indicates whether such expenses and services have been paid for, and if so, by whom; and

j. Documentation of any applicable private or governmental source of services or reimbursement relative to the alleged impairments.

2. The claimant shall furnish the Commission with as many copies of the petition as required for service upon the Program, any physician and hospital named in the petition, the Board of Medicine and the Department of Health, along with a fifteen dollar filing fee. Upon receipt of the petition the Commission shall immediately serve the program by service upon the agent designated to accept service on behalf of the Program in the plan of operation by registered or certified mail, and shall mail copies of the petition to any physician and hospital names in the petition, the Board of Medicine, and the Department of Health.

B. Upon receipt of the petition, the Board of Medicine shall evaluate the claim, and if it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the physician, it shall take any appropriate action consistent with the authority granted to the Board in §§ 54-316 through 54-325.

C. Upon receipt of the petition, the Department of Health shall evaluate the claim, and if it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the hospital at which the birth occurred, it shall take any appropriate action consistent with the authority granted to the Department of Health in Title 32.1 of this Code.

D. The program shall have thirty days from the date of service in which to file a response to the petition, and to submit relevant written information relating tot he issue of whether the injury alleged is a birth-related neurological injury, within the meaning of this chapter.

§ 38.2-5005. Tolling of statute of limitations. - The statute of limitations with respect to any civil action that may be brought by or on behalf of an injured infant allegedly arising out of or related to a birth-related injury shll be tolled by the filing of a claim in accordance with this section, and the time such claim is pending shall not be computed as part of the period within which such civil action may be brought.

§ 38.2-5006. Hearing; parties. - A. Immediately after such petition has been received, the Commission shall set the date for a hearing, which shall be held no sooner than 45 days, no later than 120 days after the filing of a peitition, and shall notify the parties thereto of the time and place of such hearing. The hearing shall be held in the city or county where the injury occurred, or in a contiguous city or county, unless otherwise

agreed to by the parties and authorized by the Commission.

B. The parties to the hearing required under this section shall include the claimant and the program.

§ 38.2-5007. Interrogatories and depositions. - Any party to a proceeding under this chapter may, upon application to the Commisssion setting forth the materiality of the evidence to be given, serve interrogatories or cause the depositions of witnesses residing within or without the Commonwealth to be taken, the costs to be taxed as expenses incurred in connection with the filing of a claim, in accordinace with subdivision 2 of § 38.2-5009. Such depositions shall be taken after giving notice and in the manner prescribed by law, for depositions in actions at law, except that they shall be directed to the Commission, the Commissioner or the deputy commissioner before whom the proceedings may be pending.

§ 38.2-5008 Determination of claims; presumption; finding of Industrial Commission binding on participants; medical advisory panel. - A. The Commission shall determine, on the basis of the evidence presented to it, the following issues:

1. Whether the injuries claimed are birth-related neurological injuries as defined in § 38.2-5001. A rebuttable presumption shall arise that the injury alleged is a birth-related neurological injury where it has been demonstrated, to the satisfaction of the Industrial Commission, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury, and that the infant was thereby rendered permanently nonambulatory, aphasic and and incontinent.

If either party disagrees with such presumption, that party shall have the burden of proving that the injuries alleged are not birth-related neurological injuries within the meaning of the Act.

2. Whether obstetrical services were delivered by a participating physician at the birth.

3. Whether the birth occurred in a participating hospital.

4. How much compensation, if any, is awardable pursuant to § 38.2-5008.

5. If the Commission determines (i) that the injury alleged is not a birth related neurological injury within the meaning of this chapter, (ii) that obstetrical services were not delivered by a participating physician at the birth, or (iii) that the birth did not occur in a participating hospital, it shall cause a copy of such determination to be sent immediately to the parties by registered or certified mail.

6. By becoming a participating physician or hospital each participant is bound for all purposes including any suit at law against a participating physician or participating hospital, by the finding of the Industrial Commission (or any appeal therefrom) with respect to whether such injury is birth related.

B. The Deans of the medical schools of the Commonwealth shall develop a plan whereby each claim filed with the Commission is reviewed by a panel of three qualified and impartial physicians. This panel shall file its report and recommendations as to whether the injury alleged is a birth-related neurological injury within the meaning of this Act with the commission at least ten days prior to the date set for hearing pursuant to § 38.2-

5006. At the request of the Commission, at least one member ofthe panel shall be available to testify at the hearing. The Commission must consider, but shall not be bound by, the recommendation of the panel.

§ 38.2-5009. Commission awards for birth-related neurological injuries; notice of award. - Upon determinign (i) that an infant has sustained a birth-related neurological injury, (ii) that obstetrical services were delivered by a participating physician at the birth, and (iii) that the birth occurred in a participating hospital, the Commisison shall make an award providing compensation for the following items relative to such injury:

1. Acutal medically necessary and reasonable expenses of medical and hospital rehabilitative, residential and custodial care and service, special equipment of facilities and related travel. However, such expenses shall not include:

a. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the federal government except to the extent prohibited by federal law;

b. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity;

c. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or federal government except to the extent prohibited by federal law; and

d. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provision of any health or sickness insurance policy or other private insurance program.

2. Expenses of medical and hospital services under subdivision of 1 of this section shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person.

3. Loss of earnings from the age of eighteen. - An infant found to have sustained a birth-related neurological injury shall be conclusively presumed to have been able to earn income from work from the age of eighteen through the age of sixty-five, if he had not been injured, in the amount of fifty percent of the average weekly wage in the Commonwealth of workers in the private, nonfarm sector.

4. Reasonable expenses incurred in connection with the filing of a claim under this chapter, including reasonable attorneys fees, which shall be subject to the approval and award of the Commission.

5. A copy of the award shall be sent immediately by registered or certified mail to the parties.

§ 38.2-5010. Rehearing on Commission determination or award. - If an application for review is made to the Commission within twenty days from the date of a determination pursuant to subdivisions 1 through 3 of § 38.2-5008, the full Commission, excluding of an award by the Commission pursuant to § 38.2-5009,

the full Commission, excluding any member of the Commission who made the determination of an award, if the first hearing was not held before the full Commission, shall review the evidence. If deemed advisable and as soon as practicable, the Commission instead may hear the parties, their representatives and witnesses and shall make a determination or award, as appropriate. Such review or determination, together with a statement of the finding of fact, rulings of law and other matters pertinent to the question at issue, shall be filed with the record of the proceedings and shall be sent immediately to the parties.

§ 38.2-5011. Conclusiveness of determination or award; appeal. - A. The determination of the Commission pursuant to subdivisions 1 through 3 of § 38.2-5008, or the award of the Commission, as provided in § 38.2-5009, if not reviewed in due time, or a determination or award of the Commission upon such review, as provided in § 38.2-5010, shall be conclusive and binding as to all questions of fact. No appeal shall be taken from the decision of one commissioner until a review of the case has been had before the full Commission, as provided in § 38.2-5010. Appeals shall lie from the full Commission to the Court of Appeals in the manner provided in the Rules of the Supreme Court.

B. The notice of appeal shall be filed with the clerk of the Commission within thirty days from the date of such determination or award or within thirty days after receipt by registered or certified mail of such determination or award. A copy of the notice of appeal shall be filed in the office of the clerk of the Court of Appeals as provided in the Rules of the Supreme Court.

C. Cases so appealed shall be placed upon the privileged docket of the Court and be heard at the next ensuing term thereof. In case of an appeal from an award of the Commission to the Court of Appeals, the appeal shall operate as a suspension of the award, and the program shall not be required to make payment of the award involved in the appeal until the questions at issue therein shall have been fully determined in accordance with the provisions of this chapter.

§ 38.2-5012. Enforcement, etc. of orders and awards. - The Commission has full authority to enforce its orders and protect itself from deception. While the language of this section is permissive and provides that a party may enforce an award in court, it must be read and considered in pari materia with the Commission's power pursuant to § 65.1-20 to punish for disobedience of its orders.

§ 38.2-5013. Limitation on claims. - Any claim under this chapter that is filed more than ten years after the birth of an infant alleged to have a birth-related neurological injury is barred.

§ 38.2-5014. Scope. - This chapter applies to all claims for birth-related neurological injuries occurring in this Commonwealth on and after January 1, 1988. The chapter shall not apply to disability or death caused by genetic or congenital abnormalities.

§ 38.2-5015. Birth-Related Neurological Injury Compensation Fund. - There is established the Birth-Related Neurological Injury Compensation Fund to finance the Virginia Birth-Related

Neurological Injury Compensation Program created by this chapter.

§ 38.2-5016. Board of directors; appointment; vacancies; term. - A. The Birth-Related Neurological Injury Compensation Program shall be governed by a board of five directors.

B. Directors shall be appointed for a term of three years or until their successors are appointed and have qualified.

C. 1. The directors shall be appointed by the Governor as follows:

a. One citizen representative;

b. One representative of participating physicians;

c. One representative of participating hospitals;

d. One representative of liability insurers; and

e. One representative of physicians other than participating physicians.

2. The Governor may select the representative of the participating physicians from a list of at least three names to be recommended by the Virginia Society of Obstetrics and Gynecology; the representative of participating hospitals from a list of at least three names to be recommended by the Virginia Hospital Association; the representative of liability insurers from a list of at least three names, one of which is recommended by the American Insurance Association, one by the Alliance of American Insurers, and one by the national Association of Independent Insurers; and the representative of physicians other than participating physicians from a list of at least three names to be recommended by the Medical Society of Virginia. In no case shall the Governor be bound to make any appointment from among the nominees of the respective associations.

D. The Governor shall promptly notify the association, which may make nominations, of any vacancy other than by expiration among the members of the Board representing a particular interest and like nominations may be made for the filling of the vacancy.

E. The directors shall act by majority vote with five directors constituting a quorum for the transaction of any business or the exercise of any power of the program. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the program. The directors shall not be subject to any personal liability with respect to the administration of the program.

F. The Board established by this section shall have the power to (i) administer the program, (ii) administer the Birth-Related Neurological Injury Compensation Fund, (iii) appoint a service company or companies to administer the payment of claims on behalf of the program, (iv) direct the investment and reinvestment of any surplus in the fund over losses and expenses, provided any investment income generated thereby remains in the fund, and (v) reinsure the risks of the fund in whole or in part.

§ 38.2-5017. Plan of operation. - A. On or before September 30, 1987, the directors of the program shall submit to the State Corporation Commission for review a proposed plan of operation consistent with this chapter.

B. The plan of operation shall provide for the efficient

administration of the program and for the prompt processing of claims made against the fund pursuant to an award under this Act. The plan shall contain other provisions including:

1. Establishment of necessary facilities;

2. Management of the fund;

3. Appointment of servicing carriers or other servicing arrangements to administer the processing of claims against the fund;

4. Initial and annual assessment of the persons and entitites listed in § 38.2-5019 to pay awards and expenses, which assessments shall be on an actuarially sound basis subject to the limits set forth in § 38.2-5019; and

5. Any other matters necessary for the efficient operation of the program.

C. The plan of operation shall be subject to approval by the State Corporation Commission after consultation with representatives of interested individuals and organizations. If the State Corporation Commission disapproves all or any part of the proposed plan of operation, the directors shall within thirty days submit for review an appropriate revised plan of operation. If the directors fail to do so, the State Corporation Commission shall promulgate a plan of operation. The plan of operation or promulgated by the State Corporation Commission shall become effective and operational upon order of the State Corporation Commission.

D. Amendments to the plan of operation may be made by the directors of the program, subject to the approval of the State Corporation Commission.

§ 38.2-5018. Assessments to be held in restricted cash account. - All assessments paid pursuant to the plan of operation, shall be held in a separate restricted cash account under the sole control of an independent fund manager to be selected by the directors. The Fund, and any income from it, shall be disbursed for the payment of awards as provided in this Act and for the payment of the expenses of administration of the fund.

§ 38.2-5019. Initial assessments. - A. On or before January 1, 1988, the following persons and entities shall pay into the fund an initial assessment in accordance with the plan of operation:

1. Physicians who wish to participate in the Virginia Birth-Related Neurological Injury Compensation Program and who otherwise qualify as participating physicians under this chapter shall pay an initial assessment of $5,000. Physicians who are employed by the Commonwealth who wish to participate in the program and who otherwise qualify as participating physicians may pay the assessment required by this subsection or or before July 31, 1988, provided they have notified the program on or before January 1, 1988, of their desire to participate in the program. Such participation shall become effective retroactive to January 1, 1988, at the time the assessment is received by the program.

2. Hospitals which wish to participate in the Virginia Birth-Related Neurological Injury program and that otherwise qualify as particpating hospitals under this chapter shall pay an initial assessment of $50 per delivery for the prior year, as

reported to the Department of Health in the most recent Annual Licensure Survey of Hospitals, not to exceed $150,000 per hospital in any one twelve-month period. State hospitals which wish to participate in the program and which otherwise qualify as participating hospitals may pay the assessment required by this subsection on or before July 31, 1988, provided they have notified the program on or before January 1, 1988, of their desire to participate. Such participation shall become effective retroactive to January 1, 1988, at the time the assessment is received by the program.

3. All physicians licensed by and practicing in the Commonwealth as of September 30, 1987, other than participating physicians, shall pay into the fund an initial assessment of $250, in the manner required by the plan of operation.

B. Upon so certifying to the program, any physician who comes within one of the following categories shall be exempt from paying the initial and annual assessments imposed upon physicians other than participating physicians pursuant to this chapter:

1. A physician who is employed by the Commonwealth and whose income from professional fees is less than an amount equal to ten percent of his annual salary.

2. A physician who is enrolled in a full-time graduate medical education program accredited by the American Council for Graduate Medical Education.

3. A physician who has retired from active clinical practice.

§ 38.2-5020. Annual assessments. - A. Beginning January 1, 1989, the persons and entitites listed in subdivisions 1 through 3 of subsection A of § 38.2-5019, as of the date determined in accordance with the plan of operation, shall pay an annual assessment in the amount equal to their initial assessments, in the manner required by the plan of operation.

B. Taking into account the assessments collected pursuant to subsection A of this section, if required to maintain the fund on an actuarially sound basis, all insurance carriers licensed to write and engaged in writing liability insurance in the Commonwealth as of September 30, 1988, shall pay into the fund an annual assessment, in an amount determined by the State Corporation Commission pursuant to subsection A of § 38.2-5021, in the manner required by the plan of operation. Liability insurance for the purposes of this provision shall include the classes of insurance defined in §§ 38.2-2-124, 38.2-125 and 38.2-130 through 38.2-132.

1. All annual assessments against liability insurance carriers shall be made on the basis of net direct premiums written for the business activitiy which forms the basis for each such entity's inclusion as a funding source for the program in the Commonwealth during the prior year ending December 31, as reported to the State Corporation Commission, and shall be in the proportion that the net direct premiums written by each an account of the business activity forming the basis for their inclusion in the program bears to the aggregate net direct premiums for all such business activity written in this Commonwealth by all such entities. For purposes of this chapter "net direct premiums written" means gross direct premiums written

in this Commonwealth on all policies of liability insurance less (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance.

2. The entities listed in this subsection shall not be individually liable for an annual assessment in excess of one quarter of one percent of that entity's net direct premiums written.

3. Liability insurance carriers shall be entitled to recover their initial and annual assessments through (i) a surcharge on future policies, (ii) a rate increase applicable prospectively, or (iii) a combination of the two, at the discretion of the State Corporation Commission.

§ 38.2-5021. Acturial investigation, valuations, gain/loss analysis; notice if assessments prove insufficient. A. The Bureau of Insurance of the State Corporation Commission shall undertake an actuarial investigation of the requirements of the fund based on the fund's experience in the first year of operation, including without limitation the assets and liabilities of the fund. Pursuant to such investigation, the State Corporation Commission shall establish the rate of contribution of the entities listed in subsection B of § 38.2-5020 for the tax year beginning January 1, 1989.

Following the initial valuation, the State Corporation Commission shall cause an actuarial valuation to be made of the assets and liabilities of the fund no less frequently than biennially. Pusuant to the results of such valuations, the State Corporation Commission shall prepare a statement as to the contribution rate applicable to contributors listed in subsection B of § 38.2-5020. However, at no time shall the rate be greater than one quarter of one percent of net direct premiums written.

B. In the event that the State Corporation Commission finds that the fund cannot be maintained on an acutarially sound basis subject to the maximum assessments listed in §§ 38.2-5019 and 38.2-5020, the Commission shall promptly notify the Speaker of the House of Delegates, the President of the Senate, and the Industrial Commission.

2. That the provisions of §§ 38.2-5002 through 38.2-5014 shall become effective on January 1, 1988.

President of the Senate

Speaker of the House of Delegates

Approved:

Governor

CERTIFICATE OF AUTHENTICITY

I HEREBY CERTIFY that the foregoing report entitled "Medical Malpractice Recommendations" is a true and correct copy from the files of the Senate Commerce Committee; this _____ day of May, 1993.

Senate Commerce Committee

By: _____